Trauma Inquiry and Response in Family Planning Webinar Transcript 12/07/2023

Nicole Nguyen:

Hi everyone. Good afternoon and thank you for joining us today for our webinar titled Trauma Inquiry and Response in Family Planning. We hope you're all doing well and staying safe. My name is Nicole Nguyen. I'm the program manager of the Family Planning program at the California Prevention Training Center. The CAPTC under contract with the California Department of Healthcare Services is sponsoring today's event. And then before we get started, I'm just going to go over some really quick housekeeping slides. So, for those not familiar with the GoToWebinar platform, so first make sure you check your audio and select your desire setting to join in through your computer audio or to call in through your phone. If your internet is a little bit shaky, we highly recommend you call in through your phone for the best possible sound and then check, make sure that you can see the GoToWebinar viewer screen with the slides on the left and the GoToWebinar control panel on the right and then this little orange box with the white arrow.

Nicole Nguyen:

This is how you can show or hide your control panel or if you accidentally clicked it, this is how you can make it appear again. And then right under that is the audio tab where you can change your audio preference at any time. And then third, please submit all your questions and comments via the questions box. Today's webinar will take about 90 minutes and include time at the end for our presenters to answer all your questions. So please send those in throughout the webinar, webinar and our speaker will address as many of them as possible till the very end. This webinar will be recorded and then responses for any questions not answered live today by our presenters will be sent out to participant at a later time. Along with the recording and the slide deck, there is an evaluation at the end, so please fill that out because your feedback is extremely important to us and really help guide us in developing our future content.

Nicole Nguyen:

And this is also how we can track your participation for CME purposes. And then speaking of CMEs, I want to acknowledge that we are working with University of Nevada Reno School of Medicine to provide CMEs for this event. This webinar will qualify as for 1.5 CMEs and is only available to those who watch the entire webinar live today. Those who watch the recording afterward will not be eligible and the link to access your certificate will be included in the follow-up email along with all the recording, the slides and the evaluation. And then for transparency, we want to state that all of the presenters, planners, and anyone in the position to control the content of this activity that has indicated they do not have any financial relationships with commercial entities related to the content of this activity. Alright, now to the fun part, we're really excited because we have two speakers joining us today.

Nicole Nguyen:

Our first speaker is Dr. Megha Shankar. She is an assistant professor of medicine at the University of California San Diego. She's originally from the Chicago area where she earned her undergraduate degree in anthropology at the University of Chicago and medical degree at the University of Illinois at Chicago College of Medicine after completing internal medicine residency at the University of Washington and a health services research fellowship at Stanford and the Palo Alto VA. Her clinical and academic work has

focused on elevating the health of women and gender diverse individuals through trauma-informed care promoting reproductive and racial justice and addressing gender-based violence. In addition to practicing primary care in San Diego, she also serves patients seeking asylum at the US Mexico border. So Megha, thank you for joining us. And then next is our speaker, Dr. Kelsey Loeliger. I'm so sorry, Loeliger. She's a complex family planning fellow at the University of California San Diego.

Nicole Nguyen:

She's originally from Baltimore, Maryland and received her MD from the Yale School of Medicine and her PhD from the Yale School of Public Health Department of Epidemiology. She graduated from Obstetrics and Gynecology residency at the University of California San Francisco. Her PhD dissertation research use statewide databases to track and ultimately improve HIV treatment outcomes for incarcerated individuals after they're released from prison or jail. Her goals in research and advocacy include addressing social determinants of health and the overlap between reproductive injustice, gender diverse healthcare, substance use disorder, incarceration, mental health and interpersonal violence and trauma. In her current work, she seeks to better understand the impact of contraception use on gender dysphoria in gender diverse individuals and without that, thank you both for joining us and I'm going to hand over the mic to you both. Thank you so much. Okay,

Dr. Megha Shankar:

Thank you so much.

Nicole Nguyen:

Go for it.

Dr. Megha Shankar:

Go ahead and share the screen. Okay, and can you all see the full screen? Great.

Nicole Nguyen:

Yes, we can.

Dr. Megha Shankar:

Okay. Okay. Good afternoon. It is so wonderful to be speaking here today on trauma inquiry and response in family planning. Thank you to the Office of Family Planning as well as the California Prevention Training Center for this opportunity. And we're so grateful for funding from the University of California ACEs Aware network as well as support from the UCSF Center to advance trauma-informed healthcare. We also want to acknowledge our project collaborators from UCSF, Dr. Bimla Schwarz and Hannah Begna, as well as from UCSD, Zoe Matticks, and Dr. Maud Arnal. In today's webinar, we will start with some background on trauma and resilience in family planning. We will then introduce the Trads framework for trauma and Resilience inquiry and go through a case emphasizing triads can be effectively applied in the family planning context to provide compassionate care for patients. We will end the webinar spending some time on healthcare staff resilience today. We're honored to be able to build on the webinar back in August by Dominica Seedman, which was entitled Trauma-Informed Care and Reproductive Health Services. Today we will build on this by discussing how to inquire about trauma and resilience and how to respond to patients with a history of trauma.

Dr. Megha Shankar:

Before we continue, we want to acknowledge that this topic is very challenging, and we want to reflect on this. If you need to pause or step out at any time for any reason, please feel free to do so. I now will offer you to join me in a collective deep breath. Go ahead and take a deep breath in and out. Thank you. We also want to recognize that family planning clinics serve diverse patient populations including gender diverse individuals. While some of the background information and statistics we present are focused on women, we know that trauma and family planning is relevant to all genders.

Dr. Megha Shankar:

So, we'll start today by talking about trauma, trauma results from an event, series of events or set of circumstances that is experienced by an individual as physically or emotionally harmful with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual wellbeing. It's important to note that there are different definitions of trauma by different groups, and we want to emphasize that all individuals may experience adversity, and this is different from trauma, which is more extreme regardless. Neither adversity nor trauma is a pathology. The context in which trauma occurs and the presence of resilience and protective factors can change the course of a traumatic event, how that event is experienced and its effects. That being said, let's talk about resilience. Resilience is the process and outcome of successfully adapting to hard life experiences, especially through mental, emotional and behavioral flexibility and adjustment to external and internal demands. This is what allows us all to still grow in the face of adversity and trauma.

Dr. Megha Shankar:

There are several examples of sources of adversity and trauma including adverse childhood experiences or ACEs, intimate partner violence or IPV and many more listed here. With these in mind, there are certain family planning patient populations specifically with the high risk of trauma, including those requesting emergency contraception, as well as those requesting for testing for pregnancy and STIs. Experiences of adversity and trauma are unfortunately very common. 65% of US adults report at least one adverse childhood experience. 39% of female veterans experience MST or military sexual trauma. Over 70,000 refugees are resettled in the US annually and up to 50,000 individuals are forced into sexual trafficking in the US per year.

Dr. Megha Shankar:

IPV and sexual violence are very common, one in two transgender individuals and one in three women experience IPV in their lifetime. Further, one in two transgender individuals and one for women experience sexual violence in their lifetime. Additionally, people of color are more likely to experience both physical and sexual violence. Focusing on IPV for a bit, we know that it is important to family planning. IPV is more common among those with STIs as well as those seeking abortion with about a 40% lifetime prevalence. Despite this in a study that reached out to almost 200 family planning clinics serving patients seeking emergency contraception, there was little to no screening for recent sexual assault. Further, IPV is a leading cause of maternal mortality, and we know that violence increases during pregnancy. Despite this, there are several counties in California that have low maternal mental health resources for the high need that does exist in our state.

Dr. Megha Shankar:

Focusing on ACEs for a bit, these are adverse events that occur in childhood such as those listed here. ACEs affect reproductive health in a dose response fashion and is associated with STIs and contraceptive choices. For example, in a 2021 study of over 400 postpartum women, those exposed to a higher number of ACEs were significantly less likely to use contraception. With this said, we can be sure to offer care no matter what to show that we are not abandoning our patients with ACEs and trauma in their times of need, offering emergency contraception and other family planning services to them. We can remind our patients that abortion is common, safe and covered by Medi-Cal, which funds abortion services regardless of trauma history. Finally, studies show that telehealth is an effective means of providing both family planning and trauma related healthcare such as contraception and IPV resources.

Dr. Megha Shankar:

Talking about trauma is a first step in promoting healing. Screening is a tool for clinicians to ask patients about their experiences and studies show that patients find clinic-based screenings such as IPV screening helpful irrespective of IPV history. In this way, universal screening and counseling can enhance patient's awareness of resources and self-efficacy to enact harm reduction behaviors. There are things to consider and barriers to screening. However, it's not clear what types of adversity and trauma to screen for, especially in the family planning setting. For example, should we screen for childhood or adult trauma? Additionally, recall can be biased, especially when we are screening for childhood adversity where ACE scores can change over time. Barriers to implementation of screening can include a lack of resources and clinics must be equipped to respond to positive screens. Further, clinicians may feel uncomfortable with screening afraid of opening Pandora's box, which is depicted in the picture here.

Dr. Megha Shankar:

That being said, there are several screening tools that can be used to ask about adversity and trauma in family planning settings IPV is the most commonly screened for and there are several tools for that as well as ACEs and other forms of violence. Here we show many of these tools and we show the ACEs screening questionnaire for adults. As an example. We note that Medi-Cal providers are eligible for reimbursement for conducting such screenings and different clinics may be using different tools just as we can screen for adversity and trauma. We can also screen for resilience. There are several validated tools listed here that can be used and we showed the brief resilience scale or BRS here as an example. Clinicians can use patient responses to these tools as a way to provide strengths-based healthcare.

Dr. Megha Shankar:

So now moving from screening to trauma and resilience in inquiry, this is an active process that includes asking open-ended questions and dialogue in order to understand the context of patient symptoms and provide effective treatment. Broad inquiry can begin with a simple question. Have you had any life experiences that you feel has impacted your health? If so, how? Inquiry focused on symptoms rather than events can identify how trauma impacts health. There's no need to pry for details. The goal is to provide a safe environment for patients to share as much or as little of the event as they choose. The goal again, is not disclosure. Responding to trauma requires a focus on resilience and strengths, both as a resource and as a way to avoid re-traumatization trauma. Inquiry integrates well with universal precautions. In studies with family planning clinics, a brief trauma assessment and support intervention was found to be acceptable by diverse patients and found to be effective in communicating provider

caring as well as increased knowledge of resources. In this way, trauma inquiry includes a foundation of trauma-informed care education describing the relationship between trauma and health and response that is empathetic and effective.

Dr. Megha Shankar:

So, this brings us to triads Trauma and Resilience. Informed inquiry for adversity, distress and strength. Triads is a framework for trauma and resilience inquiry developed by Dr. Alicia Lieberman and colleagues with the UCSF Center to advance trauma-informed healthcare triads was initially developed to build on ACEs screening, which can seem sometimes like a checkbox, and so the triads framework provides a structure to guide conversations and dialogue between a clinician and patient. While triads focus on ACEs in primary care, it can be effectively applied to trauma in family planning. As the name suggests, triads have three components, one inquiring about adversity, two, assessing distress, and three identifying strengths. This process begins with asking with empathetic interest about the patient's experiences of adversity, then linking adverse life experiences to health in a supportive and non-judgmental manner and guiding the patient to identify personal strengths that support wellbeing. We know that this can be really hard in clinical practice, so we want to share the perspective of OB GYN, Dr. Sarah Johnson, who will speak about how she applies the triads framework and finds it effective in her work.

YouTube Video:

One thing that the relational triads approach does is bring something that can feel pretty huge when you're a clinician into a kind of concrete operationalizable format. So, if you're a clinician and you're used to sort of saying, oh, your review system's very concrete, does your knee hurt? Does your toe hurt? How are your allergy symptoms? And then now we're suddenly taking on something like what are all of your difficult life experiences and how have they affected you? It can still kind of overwhelming I think to bring in this element, especially because we've so traditionally separated mental and physical health and we know we're not mental health professionals. If you're thinking about trying to screen for ACEs and you're thinking, okay, I need the four Rs from SAMHSA and I need the seven principles of trauma-informed care, how to bring that into a conversation is actually pretty challenging, but they're actually kind of baked into triads and it's just three elements that really help you connect with your patient in apathic strength based way and bring this, these things that the patient's carrying with them that affect their health into the clinical encounter. So just kind of what happened, how did it affect you and what helps those three elements, they're easy to remember and if you go through them, you'll be having a conversation with your patient that really brings in the principles of trauma-informed care into your clinical encounter in a way that can be a conversation that makes sense in the kind of visits that we have patients.

Dr. Megha Shankar:

So, in this way, as you said, triads is meant to be accessible to all clinicians, emphasizing that you don't have to be a therapist to be therapeutic. I'll now hand it over to Kelsey to apply triads to a family planning case.

Dr. Kelsey Loeliger:

Thank you Megha. So, our case is that of Maya, a patient who's presenting to family planning clinic for emergency contraception will walk through this case drawing upon each of the three aspects of triads, discussing the key points and how to effectively use the triads framework. Next slide.

Dr. Megha Shankar:

So

Dr. Kelsey Loeliger:

Maya calls the clinic and arrives for her appointment. Key points to note here are that healthcare settings can be re-traumatizing for patients, especially those seeking family planning services. And this can reduce healthcare utilization by patients ensuring that clinics are trauma-informed from the front desk staff to the clinicians can be a way to prevent re-traumatization, build trust and promote strengths. For example, clinic staff who respond to patient calls should know the available family planning services. In a study that reached out to 407 family planning clinic call staff, only 12% recorded offering medication abortion services and 68% of clinics that did not offer those services could not provide recommendations for clinics that did. There are also several trauma-informed front desk practices that are pretty easy to incorporate. Those include using gender pronouns, protecting patient privacy, including signs in the waiting rooms and allowing for flexible clinic policies. Next slide.

Dr. Kelsey Loeliger:

So, coming back to our case, Maya is then roomed by the medical assistant. This is an opportunity to put the triads framework into action starting with inquiring about adversity. In many clinics, the MA completes any required screenings such as ACEs or IPV screening. If this is the case, it is important to screen in private in the room with the patient alone. If this is not possible, then we recommend against screening as this can cause more harm. Screening can be done in several modalities to protect privacy and patient comfort, and it is key to normalize screening and combine this with existing workflows such as asking about substance use disorders and depression. If screening is being done using validated tools, the MA can preface and normalize screening. For example, with a statement like, unfortunately, violence is common for many people. We ask everyone some questions about their experiences with violence because it can affect health.

Dr. Kelsey Loeliger:

Would it be okay for me to ask you a few questions about this? If there's a positive screen, we recommend the MA provides an empathetic response like, I'm so sorry that this happened to you. Would it be okay if the clinician talks with you more about this here? It is crucial to pause after asking that question and to genuinely allow the patient time for a response after this disclosure, it is important to minimize the time the patient is waiting alone in the room, and of course it goes without saying that patients can decline to discuss their trauma. There should just be at some point a routine safety assessment to assess for suicide risk and to make sure that it is actually okay and appropriate to stop any further discussion. Next slide.

Dr. Kelsey Loeliger:

So Maya is now in the room with the family planning clinician, and she asked for emergency contraception. Here we recommend inquiring about adversity, remembering that the impact of trauma and adversity is relational. We recommend practicing the three Cs, making a meaningful connection with the patient and then making sense and explaining coherently to show your understanding and finally collaborating with the patient to show your support in inquiring about adversity and trauma, we recommend connecting it to family planning needs. For example, in this case, you can say, I'm happy to help you with emergency contraception. Do you mind if I ask you a few questions to better understand your health needs? After pausing for a response, you can then ask about a number of things like sexual violence in a variety of ways. So, for example, one way of asking would be the sex that you had consensual something that you wanted to do? When patients are asking for emergency contraception, consider the possibility of experiences like sexual assault, sex trafficking, or marital rape among others. This is because patients seeking family planning services like emergency contraception, pregnancy testing, and STI screening are at higher risk for trauma. Often patients requesting pregnancy testing need emergency contraception but don't know how to ask for it. So, if we ask about trauma, this can help guide appropriate clinical services for the patient. Next slide.

Dr. Kelsey Loeliger:

So, after trauma inquiry, Maya shares with us that she experienced reproductive coercion and that her partner refused to use a condom. She tells you that she's experiencing a lot of pressure to have more children from her partner and his family. It's important to note that trauma like this can impact reproductive health in a number of ways, including risk of STIs, premenstrual dysphoric disorder, PTSD, infertility, contraception use, pregnancy and birth outcomes and endometriosis and menopausal symptoms. So, using the triads component of recognizing signs of distress. When clinicians discuss with patients the impacts of trauma on health, this can promote trust and shift the discussion away from a pressured disclosure of trauma scenario towards more skills building and resilience. Furthermore, studies show that clinicians with greater knowledge of trauma who feel more equipped to discuss it are more likely to inquire about it in the first place and then have better rapport with their patients as a result.

Dr. Kelsey Loeliger:

Next slide. Yes. In Maya's experience, we can recognize signs of distress, the second part of the triad’s framework, and we can connect trauma with sexual health by saying, I'm so sorry that this happened to you. Experiences like this can cause a variety of health issues. Would it be okay if I asked you more questions about your health? We can then ask about sexual health behaviors and symptoms of sexually transmitted infections. For instance, the experiences that patients share should guide the rest of your visit. If we learn that there are symptoms that require physical exam, we can ask about triggers when performing a pelvic exam is especially important to ask about this and we can say something like, before we proceed with the physical exam, is there anything else you think I should know? Or have you had a speculum exam or pap smear done in the past? How was this experience for you? You can also help to empower patients during the physical exam by asking if they prefer to do their own self swab for STI screening or to place their own speculum or vaginal ultrasound probe to promote trauma-informed care.

Dr. Kelsey Loeliger:

I want to take a moment just to talk about the concept of the trauma-informed exam. There are specific trainings that exist for how to perform a trauma-informed pelvic exam, which are definitely worth looking into. This slide was taken from the UCSF Reproductive Health Access project website, which is one of many resources. I like this reference because it goes through the exam step-by-step, starting with establishing rapport beforehand. This may actually require the patient to return for a second visit if they don't feel ready for the exam. It may help to have a support person present, but make sure this request is coming from the patient themselves, not the support person. Allow the patient to request a female examiner. I know this can be challenging based on provider availability, but in cases of trauma, it makes sense to try to accommodate this request. When possible, encourage patients to verbalize if anything is uncomfortable, overwhelming, or if they need you to stop or pause, say out loud that the patient is in control of everything that happens in the room and the exam can be stopped at any time.

Dr. Kelsey Loeliger:

Try to keep the patient's legs covered and pull up the sheet in the middle to expose only what is necessary. Remind patients to breathe. When introducing the speculum, you can rest it against the vagina first to allow them to get used to the sensation before it is inserted and then check in with the patient at this point to make sure it's okay to continue the exam. Also, try to use the smallest possible speculum that you feel comfortable using. You obviously need to be able to do your job, but sometimes a slightly smaller speculum can make a big difference. And then call the stirrups. Footrests. On this note, it helps to develop your own spiel for how to perform a pelvic exam with a consideration for avoiding certain terms. In my practice, I'm careful to avoid terms like bed open touch and relax, which are all words that could have been spoken to a patient during a previously traumatizing encounter for positioning.

Dr. Kelsey Loeliger:

For example, you can ask patients to move down to the edge of the table, not the bed. You can use the phrase, try to let go of the muscles in your legs so that your legs fall to the sides, like an open book. And you can also say, let the muscles in your bottom relax down to the floor. And my preferred phrase for another part of the exam, especially when you're getting ready to place the speculum can be, you'll feel my glove here. Is it okay to continue with the exam? And then I also just want to make another statement about patients. There are patients that have, for example, significant vaginismus to the point where placement of anything, even a Q-tip can be difficult. So, your clinic may or may not have the ability to offer various medications such as oral sedation to help ease the experience. Even if these medications are not available, you may be able to consider offering something like tropical lidocaine that patients can place themselves prior to the exam. And I think the most important piece here is not necessarily what you end up using or what you end up doing, but really the process of collaborating with the patient to come up with a plan for a pelvic exam that they can be comfortable with builds trust and helps the patient to understand that they actually are in control of the entire experience. Next slide.

Dr. Kelsey Loeliger:

Can you go to the next slide? Me actually? Okay. And then go back.

Dr. Kelsey Loeliger:

Okay. I think we may have a misplaced slide, but I will just say what I wanted to say, which is that Maya chooses a form of emergency contraception that works for her. She, we talk to her, we learn about what has worked for her in the past and that she also has a desire for invisible options as her partner tracks her menstrual cycle. She states that she has used an IUD in the past and she decides to have a copper IUD placed. She's visibly anxious about her IUD placement and shares that pelvic exams are difficult for her, but she does very well with a trauma-informed pelvic exam.

Dr. Kelsey Loeliger:

And I want to take this opportunity to say that continuing to our third and final component of triads, we want to focus on strengths as a way to promote resilience and empowerment. So, when it comes to contraceptive care, the best type is the one that patients want to use right now. And this may be no method at all. There are also various invisible options such as injections, implants, or IUDs. And so just a few quick plugs about some considerations to note about some of these methods is that the copper IUD could be a good option if your patient cycle is being tracked. Even if it's being tracked with an ovulation kit, some partners may feel the strings. So that's something you can discuss with your patient, and you may potentially cut the strings very short to try to avoid that. And there is now the option of IUD self-removal, which some patients may find empowering to just know that that option exists for them.

Dr. Kelsey Loeliger:

They don't necessarily need to make an appointment if they think they're able to remove the IUD themselves. I also just wanted to talk about the subdermal implant. It's a great option, but it does require training for placement. And studies show that only a minority of family planning providers have received Nexplanon or subdermal implant placement training. So, if you have the option to get access to this training or to offer it at the clinic where you work, that is definitely a valuable skillset. You just may need to discuss with your patient whether they need an explanation for the band aid or bandage that they might have on their arm for the first 24 hours. And in some cases, you might just be able to modify how you dress the incision. And then finally, don't forget to offer a prescription for emergency contraception and to counsel patients on how it works and how to use it. Studies show that the majority of adolescents counseled on emergency contraception don't remember most of the details on how to use it. So, this suggests that information needs to be provided and then just reinforced whenever we have that opportunity, so patients really know that this is a tool available to them.

Dr. Kelsey Loeliger:

And on this slide, I want to speak for a minute about supporting natural coping mechanisms. This can be done by asking patients about their support systems and if there's anything we can do to help them feel safer. Shared decision-making, motivational interviewing and strengths-based approaches to care can be a tool to address health issues and distress related to trauma. And in turn, this can lower mental health related trauma symptoms. And so, bringing it back to family planning settings, feeling in control of one's bodily autonomy such as reproductive health choices and feeling safe and in control during pelvic exams can really empower patients and prevent retraumatizing them during clinical encounters. Similarly, understanding trauma can help prevent generational cycles of trauma. By building parental resilience skills and capacity, we can help build resilience using this mnemonic, understanding that different patients find resilience through a variety of ways such as religion, social support, and cultural assets.

Dr. Kelsey Loeliger:

Next slide. Okay. So, after receiving emergency contraception, Maya leaves the clinic at the end of her visit. Returning to our triads model, she was provided community resources as a way to help her to identify strengths, and the front desk also helped her to set up a primary care follow-up appointment. Providing resources as a universal precaution is recommended because resources can be helpful for those with or without experiences of trauma. And so, providing resources for everyone to use if and when they prefer is a way to promote self-efficacy and empowerment. Resources, particularly relevant to family planning can include the National Domestic Violence Hotline and the Sexual Assault Hotline along with local community organizations. For those with a positive trauma history, we also recommend discussing safety planning referral to mental health services, and importantly asking patients their preferences regarding documentation. For example, some patients may be comfortable discussing resources, but want to minimize documentation that their partner could have access to. This brings us to the end of our case. Next slide. In addition to resources like national hotlines, we also wanted to share some resources developed by Futures Without Violence, which is a health and social justice nonprofit that seeks to address trauma and violence. These are examples here on the slide of patient facing information cards that clinics can access on the Future without Violence website and can be printed for patients as a universal precaution. Examples of the various topics that they cover include reproductive coercion, protecting anonymity, and clandestine birth control method options.

Dr. Megha Shankar:

Alright, thank you so much, Kelsey. As a recap of the triad's application to our family planning case, we wanted to share a different way this can look like in clinical practice. So, this is a video which can be found on the triad's website of an example of how an OB GYN responds to an ACEs screening during a prenatal visit.

YouTube Video:

So, thank you for filling this out and just to reflect back to you that, as I said, we're asking these things because these experiences are so common. So, your comment among our patients and having had those experiences, and it sounds like you're wondering about the connection to your health issues. If you don't mind my asking, how do you feel like your experience has affected you? Something you said about tension. I feel like sometimes where I have the chronic pain, although it's my symptoms, so yeah, it feels like it's certain parts of my body almost like you're bracing yourself and then doing that in an ongoing way over time, it's kind of causing, well, isn't it interesting when we notice and pay attention, we actually can undo it a little bit. Yeah, yeah. Well, what's helped you in the past besides just noticing and letting it go?

YouTube Video:

I'm even putting up screen now. Yeah, I think I should notice practice noticing, but one time I realized there was a stretch of four days where I didn't have any back pain at all, and I feel like I should be able to do that while I'm home. Maybe have little trips instead of waiting for. Yeah. Well, that's really interesting, first of all, just to acknowledge that even just your awareness that you're describing is actually a really powerful tool for this and for all kinds of unpacking the way our experiences affect our house. So that's really great. And it sounds like maybe you're even talking about, I don't know if you noticed on that list, but experiencing nature can actually help us regulate our tension and stress and physiology. So

Dr. Megha Shankar:

Great. Thanks for watching that. And again, that can be found on the triad's website in addition to several other videos. So, we will wrap up and move to the final part of our talk and briefly take a moment to acknowledge that as clinicians, we all may have experiences with adversity and trauma ourselves. And this can be primary traumatic experiences or secondary trauma, which is defined as emotional duress, which results when an individual hears about the firsthand trauma experiences of another. Given this asking patient about trauma can be triggering. So, healthcare staff resilience is so, so important.

Dr. Megha Shankar:

Caring for yourself is caring for your patient. There are several ways to care for yourself, especially in the moment. And everyone's approach can be different. These might include breathing exercises or mindfulness practices. And one specific approach that might be helpful is something called compassionate detachment, which is the ability to maintain empathy and compassion towards others while establishing emotional boundaries to protect one's own mental and emotional wellbeing. One example of practicing this is to acknowledge that you may create mental images of trauma when you hear it. So, it can be helpful in this case to summon a competing image to counter this. Another example is to position yourself by sitting up straight and placing your feet firmly beneath you When discussing trauma, this is a way to ground yourself or you might find yourself hearing a patient describe a traumatic experience and feel re-traumatized. If this is the case, it is okay to say something like, I'm so sorry, this is very painful for me to hear. Would it be okay if we moved on to a different topic and studies show that patients do respond well to this. Finally, it can be helpful to debrief with colleagues, but remember to ask permission first, do you mind if I share a challenging patient story with you? Whatever you choose, we encourage you to reflect on your experiences, potential triggers and strengths.

Dr. Megha Shankar:

So, we come to the end of our webinar and want to review a couple of take-home points. We want to emphasize that trauma, inquiry and resilience, inquiry and response, it matters in family planning. The triads framework can be an effective way to guide conversations with patients about trauma and resilience. And the triads website shown here has a lot more information and resources to learn more. We show a screenshot here of the website, and as you can see, there are several other resources that are very helpful. Finally, we would love your feedback and would also like to offer an opportunity for further training in small group small group discussions. We know that there are so many challenges of the changing clinical landscape, and it can be so hard to apply this work to your day-to-day. So further training can be helpful to share practices and brainstorm with colleagues.

Dr. Megha Shankar:

I want to note that this is part of a larger study between UCSF and UCSD to investigate trauma inquiry in family planning. And we would love for you to be a part of this and partner with you. So please scan this QR code or click the link, which will be put in the chat for a very brief three question survey of today's webinar and to indicate interest in further training. So, I'll leave this QR code and the link up here for a moment and give time for folks to complete the survey right now. So, I'll just keep quiet for a minute and allow folks to go ahead and scan that QR code and take that survey if you're open to it.

Dr. Megha Shankar:

Okay, great. Hopefully that's enough time for folks to fill that out. And if not, the link again is in the chat. I'm going to go ahead and stop sharing my screen. I just want to say thank you all so much. My email is up here. If there are any questions about the webinar today or the study that we are conducting, I'm just going to show our references here. All of these slides will be emailed to you and I'll stop sharing briefly, but I do want to show there was one slide that we missed and Kelsey did an amazing job walking through it and talking through the specifics, but I do want to give a visual for that because I think it's so important. I just give me a moment here.

Dr. Megha Shankar:

Okay.

Dr. Megha Shankar:

So, I just want to go back to this part very briefly since somehow this slide was missed from our presentation, but Kelsey talked about this, and we want to emphasize here that this is the third part of the trads framework or identifying strengths as Kelsey talked about. We learn in our case that Maya has had an IUD before and feels comfortable with this. We also learn that her menstrual cycle is being tracked. And so, through shared decision-making decide on a copper IUD, which is both emergency contraception as well as long-term contraception that is aligned with her goals. So, I'll go ahead and stop sharing my screen and we'll go ahead and go through our question and answers. Give me a moment to pull up the questions here. Okay,

Dr. Megha Shankar:

So, one of the questions is, should providers be using triads, or can medical assistants be using this as well? This is a great question and I think the important piece here is that anyone can use triads. And again, it is a framework and a guide. It's not meant to be a prescription or a checklist. And so, it's a guide for conversation and every clinician from end clinical staff, from the front desk staff to MAs, RNs, MDs and so on will be having conversations with patients and can lean on triads as a guide for having those conversations. And so, while it's important to discuss within your clinics what the role of every level of provider is in providing family planning care and how in depth to go in some of these conversations, we do want to emphasize that triads are really available to anybody. And it just goes back to the important point that you don't have to be a therapist to be therapeutic. You don't have to be a doctor to be therapeutic. It's really in the conversations that we have with our patients and those conversations can be guided by.

Dr. Megha Shankar:

Alright, and so this question is on the trauma-informed pelvic exam. So, I'll read it out loud and Kelsey would love to have your thoughts on this. So, these examples of trauma-informed pelvic exams are excellent. How do you suggest providers to use these recommendations with limited time and high patient loads? I can imagine clinicians won't have time to engage patients as needed. And so I'll briefly start and just say, in my clinical practice in primary care, I use all of these tools and I find that it really doesn't take that much time and it's not so much that we use every single thing that was listed on that slide, but more so we tailor it to every patient based off of the feedback we receive from them. Of course, in primary care we might know them for longer, so we know their preferences. That might not be the case in family planning all the time, but these are all suggestions and not something again that

you have to go down the list of everyone. It really integrates pretty seamlessly. But I'll let Kelsey answer any other perspectives from her family planning experience.

Dr. Kelsey Loeliger:

Yeah, that's one of the reasons that I like to ask patients how prior exams have gone because a pretty good indicator for whether sort of your level of caution. Obviously every exam should be done with some level of sensitivity for the potential for trauma, but if a patient says, oh yeah, no pap smears are fine, no problem, then I'm probably going to spend a lot less time talking them through the steps for someone that I know it's going to be a challenging exam. I take just a minute or two to very clearly explain exactly what this exam is going to entail. And then I always say, if you need me to stop, pause or just what I'm doing, please tell me you are in control of everything that happens here. And that only takes probably less than a minute to say, but then you've laid that foundation and then the rest is just what you're saying as you go through the steps of the exam. So, it doesn't necessarily add that much time to the exam itself is just how you're framing it. And I find that taking those few additional minutes, the rapport that you have and the difference that it makes is definitely worth it every time. But definitely picking and choosing and I think that's why it helps to also develop your own spiel, then it becomes really easy, and it just integrates into your workflow.

Dr. Megha Shankar:

Great. Some of these next questions I think we can both address as well. So, let's see here. A couple of questions on IUD strings. One question is, I've heard that cutting the strings very short could actually lead to partners noticing strings if the IUD moves a little bit lower into the uterus. Any thoughts or data on cutting the strings actually longer and then similarly or any other advice for IED strings and possible partner detection? So, I'll let Kelsey enter this as well.

Dr. Kelsey Loeliger:

Yeah, I'm glad that you brought that up. That's something that I think I personally err on the side of cutting strings longer because I think they tuck back better. And I agree that it's easier for a partner to feel like a pokey short string than a longer curled string. I have seen cases where people are so worried about detection that they're essentially in a shared decision-making way, choosing to have their strings cut very, very short. I personally worry about that a little bit. I worry it could also make removal more challenging again if the IED moves a bit so that the length of the string is definitely something, I don't have a sweeping generalization for that. I think it's something that you have to talk to the patient about. And then also kind of have a plan with the patient for if their partner is feeling it, what would they do? Would they be able to make an appointment to come back? Would they try to remove it themselves? I think just planning for those scenarios can be helpful as well.

Dr. Megha Shankar:

Great. And I think in a similar vein, someone asked if we could speak more to IUD self-removal, so I'll let you answer that as well.

Dr. Kelsey Loeliger:

Yes, this is definitely a newer practice. There isn't necessarily that I'm aware of a protocol out there for it, but essentially if a patient can feel their strings, if they're able to do their own exam with a clean hand and they're able to feel their strings, then they can remove their IUD safely. Exceptions are if they're not

really able to get a good grasp and they pull it partially out, that could be problematic. Or there are sometimes cases of IUDs being embedded and they won't actually come out. But in general, it's safe for a patient to do their own removal and if for some reason they're unable to then come in for an appointment. This isn't something that I generally have talked to a lot of patients about, but it's known that it is a safe option for a patient if that is something that's going to make a difference in their lives. And if they need their ID removed and they can't make it in or their behaviors are being watched, I think it's helpful to know that's something that you could tell your patient about.

Dr. Megha Shankar:

Great. And we have a person in the audience who gave us a great resource on this. It's the reproductive health access website again that Kelsey mentioned. If you just Google reproductive health access IUD self-removal, that website should come up. Great, thank you.

Dr. Megha Shankar:

And then let's see here. Okay, there's a question that says, I think we can expect some people to not have thought about how their trauma has impacted them. How then do we respond to someone saying, I don't know, I tried not to think about it. I think that is a really, really important question and something that we will encounter and that's okay. Such an important piece of trauma inquiry and resilience inquiry is allowing the patients to guide the conversation. And if they say something like, I try not to think about it, it's okay to let that conversation go. More importantly in that case is to provide universal precautions. So, by this we mean we give resources about trauma to every patient regardless of their history of trauma. And again, in a lot of studies specifically, a lot of studies have focused on intimate partner violence, giving resources about intimate partner violence, even if someone doesn't have a history of it, has been found to be very helpful.

Dr. Megha Shankar:

And what we end up seeing patients do in these cases, sometimes if they haven't thought about it or they don't feel like they've experienced this kind of trauma, they will say like, oh, great, I will take this resource. Maybe I'll hand it to a friend or a sibling. And we found this to be such a nice way of sharing resources in a way that is community oriented, and relationship centered. So again, I think the main point here is allow the patient to really guide the conversation about trauma themselves. The goal is not disclosure, the goal is not to force them to describe any details, but just to really plant the seed that something in their life might have impacted their current health experiences. Great question. Okay. And then there's a question here. What if it was a man that had been sexually abused? You mentioned asking the women if she would be comfortable doing a pelvic exam and doing a swab herself or the ultrasound probe. What are the recommendations of protocols you have for a male that has been sexually abused? Another excellent, excellent question. We know that men also experience sexual violence, and same thing applies here. So, when we think about any kind of swabs, like for example, STI testing, we offer this self-swab or for example, rectal, STI testing or throat, STI testing, those can be done on a patient can self-swab themselves. So really similar things here. Allow the patient to be in control of whatever exam, whether it's a pelvic exam or a male GU exam.

Dr. Kelsey Loeliger:

And I'll just add, I mean this goes without saying, but I think just being really explicit about exactly how to do these swabs because it sometimes seems really obvious, but if someone isn't actually going to do

the rectal swab properly, you really just have to be very clear about exactly what's involved so that you can also get good results and they don't have to come back.

Dr. Megha Shankar:

Thank you. Okay. Let's see. Shifting through here, there's one question earlier on. Do family planning clinics have licensed mental health providers, an example, licensed marriage and family therapists on staff to address trauma and health concerns? Where does mental and behavioral health intersect with family planning? Hopefully our webinar shows, especially in the background and statistics section, that there is a huge intersection between mental health and family planning. And in terms of resources, it's a really great question. Every clinic is different. Some may have access to licensed mental health providers, some may not. You might consider partnering with primary care, which might have some more resources around that. So, it really is clinic dependent. But I do want to note here that it really goes back to this idea of if we're performing screening, we really need to have resources to be able to address a positive screen. So, in terms of clinics and individual clinicians starting screening, starting trauma inquiry, really, really important beforehand to have resources, even if it's providing the crisis line, which is something we can all do and doesn't require an integrated mental health model. And so, know about your resources. I think we provided a lot that can be found by anybody online. And you'll be able to see that in the slides as well as in the handout, which is attached here. So really, really important question.

Dr. Megha Shankar:

Okay, there's a question here. What were the words that you shouldn't use that may be triggering when doing a pelvic exam that Kelsey had mentioned? Kelsey, I'll let you go through those again.

Dr. Kelsey Loeliger:

Yes, I don't have my slides pulled up, but I think things like bed open touch and relax, which are things that sounds like it sounds very benign to say like, oh, hey, just relax your legs out to the side. But even that term can be problematic. So yeah, that's why. And there's others too. This isn't a comprehensive list, but that's why over the years, I use the phrase, allow the muscles in your legs, let go of the muscles in your legs so that your legs can fall to the sides. Like an open book, for example.

Dr. Megha Shankar:

Yeah, absolutely. And I'll just add one more word to avoid, which is red. So, we don't want to ask patients to spread their legs, for example. Great. Okay. Let's see here.

Dr. Megha Shankar:

So, an interesting point was talked about briefly, the staff themselves are dealing with trauma. Is there additional training? Training for staff? And there are trainings for staff. I think sometimes these trainings are offered by clinics and they might be under secondary trauma, vicarious trauma or healthcare traumatization. And so, these might be helpful to ask your clinic. And then there are also resources online that we can send as well. Okay. There is a question here about related questions. So how would you recommend a woman respond to her partner who has found out that she's using contraception and he was not aware? How do you prepare her for that? And similarly, wouldn't a partner suspect something if the patient isn't getting pregnant, which could lead to more problems? So really, really great questions. I'll have Kelsey answer these.

Dr. Kelsey Loeliger:

Yeah, I don't think there's a good answer to that. Everyone's situation is so different. So, it would be hard as a provider to make assumptions.

Dr. Kelsey Loeliger:

About how a partner might respond or what a partner might think about what's going on. I think the best thing that you can do is talk to the patient about the possibilities. If this is something the patient's worried about, you can ask, do you feel like this method is something that you'd be able to keep your partner from finding out about? What do you think? What would you worry about if your partner found out? What could you do? Is there someone in your life that you could go to for support or safety? You can provide resources to women's shelters and various things. So again, that's part of safety planning really is having a plan B and a plan C am not personally aware. I'd love for people share in the chat. I'm not personally aware of a recommended script for a patient to use when discussing this with their partner. I think it obviously has to be tailored to the individual relationship. And some patients are very good. I mean, some patients are very good at navigating these situations as uncomfortable or unsafe as it may be. But I don't personally know of a recommended script that a patient could use to try to have that conversation. I think I would probably focus mostly on safety planning and knowing what their resources would be.

Dr. Megha Shankar:

Yeah, I really appreciate this question and I want to emphasize the safety planning again because I think especially when it comes to intimate partner violence, these situations are oftentimes such a high risk for homicide and safety planning is really the tool that we have to help patients get help in these moments of crisis. So, making sure every time you meet a patient, giving them the crisis hotline, talking to them about their resources. And that goes back to identifying strengths. Do they have someone on speed dial? I just learned that we are now able to text 9 1 1. So, a lot of the crisis lines can work via text if it's too cumbersome to call. So, texting 9 1 1 or the crisis lines can be a way for this as well.

Dr. Megha Shankar:

Okay. Let's see. Okay, great question here. People seem to feel really guilty about having bad coping mechanisms like smoking drugs, unprotected sex. Do you have a method to break through the medical TSD many folks have from being told they are bad for what they had to do to survive? I think this is such an important question and some of the scripts or lines that I've used in the past for this, if someone discloses to me and I can tell that they carry a lot of shame with this, oh, I started using again. We really talk about what's going on in their life. And again, using triads as a guide to have this conversation saying, oh my gosh, you've experienced so much. You're going through so much right now. Of course, you're using and taking that stigma and burden off the patient by saying, of course this makes sense.

Dr. Megha Shankar:

And then acknowledging that and then redirecting coping mechanisms and educating those coping mechanisms, all coping and there can be positive and less helpful coping mechanisms. And so, saying instead, what has worked for you in the past when you quit smoking 10 years ago, what helped you at that time? And let's go back to identifying those strengths and redirecting to more positive coping mechanisms. Whether that is relying on a friend, kind of like a buddy system, maybe it's journaling, maybe it's getting back into touch with a therapist. And so, these can be so many different things to

redirect. But I think that first part about acknowledging, of course you've gone back to smoking, you're going through so much and just acknowledging that can really take that burden of stigma off of a patient. Okay. Let's see here. I am just going to share my screen again because I think there are a couple more questions about that trauma-informed pelvic exam tips. So, give me one moment about specific words to use and things like that. So, I'll just show it again here.

Dr. Kelsey Loeliger:

I think some of the words are in the notes, so they might not be on the slide, but

Dr. Megha Shankar:

Let's see. There we go. Okay. Yeah.

Dr. Megha Shankar:

Okay.

Dr. Megha Shankar:

Yeah, I think the question follow-up question was specifically about what to use. So, words to use instead of relax and then also what to use instead of stir up. So again here, rest would be one way. And then really encouraging the patient to breathe so that some of the wordings was allowing their muscles to kind of fall to the floor or fall to the side.

Dr. Kelsey Loeliger:

I say, let go of these muscles instead of relax. I think that is helpful.

Dr. Megha Shankar:

Perfect. I'll stop sharing and again, you'll receive these slides. Okay. There's one comment here, which I love on. So, as we mentioned, we are working with the University of California ACEs Aware initiative and funded through them. And it might be helpful here to learn from one of our participants that the ACEs Aware initiative has a program to give small grants and technical assistance to clinics who are interested in starting ACEs screening. The email is questions at ACEs aware do org and the program is iLab pilot program. So, we'll try to get that information into the chat in just a little bit. Okay. Let's see. Yeah, so I think this, I'm just going through, I think these are most of our questions. Let me just do a quick run through to make sure there's nothing else that I missed. Yeah, I think there are some that might be it. Just some comments about there are unfortunately in the system and structure that we all live and work in, there are instances that are not supportive, not trauma informed, and we can make a small change and hopefully a big change as we all continue to practice trauma-informed care. Continue to just start these conversations about trauma and resilience in inquiry with our patients and most importantly, allow the patients to guide the conversation and really empower them. I think that was the last question here,

Dr. Megha Shankar:

So, I will give it a minute more to see if there are others that come through. Otherwise, I'll pass it back to Nicole.

Nicole Nguyen:

Yes, thank you so much. Yes, so I think you've pretty much answered all of them. I don't see any new ones coming in, but if there's anyone that we slip through the class, we'll definitely collect them. But yes, I think that was it. Thank you so much this week getting feedback. And there's some that share really emotional responses that this has helped really a lot for themselves or their staff as staff or as their interaction with patients. So, I want to thank you both Kelsey and Megha for presenting this. This has been really, really good and a very much needed topic for family planning clinics. So, I think for that, that concludes our webinar. So again, just remember we'll have a survey that goes out to evaluate once this webinar ends to give feedback. And again, I know Megha and Kelsey also have that QR code.

Nicole Nguyen:

There's the link in the chat. So, if you didn't have a chance to fill out their survey, in case you're interested in additional training and more information on the triad's framework, please fill that out as well. And then just a reminder, we'll send everything out your certificate link for the CMEs, recording all the slides, and then the fact sheet that Megha and Kelsey shared after the webinar ends. So, I think that is it. Thank you so much and we hope you enjoyed and stay safe and a happy holiday for everyone for early. Thank you so much. Take care. Bye.